EXHIBIT C

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

MAIL TO:
SHEET METAL WORKERS NAT'L HEA
P O BOX 1449
GOODLETTSVILLE, TN 37070

APPROVED OMB-0938-0008
RETURN
SMWN 0001
00113
SECONDARY

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) [X]
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY: 04 20 1937 — SEX: M [ ] F [X]
4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street)

CITY: SPRINGFIELD — STATE: MA
8. PATIENT STATUS: Single [ ] Married [X] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY: SPRINGFIELD — STATE: MA

ZIP CODE: 01118-0000 — TELEPHONE (Include Area Code)
ZIP CODE: 01118-0000 — TELEPHONE (INCLUDE AREA CODE)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY: 03 07 1937 — SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: 04 20 1937 — SEX: M [ ] F [X]
b. AUTO ACCIDENT? PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME

REDACTED

c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: SHEET METAL WORKERS NAT'L

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE - MASS
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE — DATE 11-17-03

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: HETZEL, PAUL C.
17a. I.D. NUMBER OF REFERRING PHYSICIAN: A68203
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? [ ] YES [X] NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 174.9
2. 288.0
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24.

	A From MM DD YY	A To MM DD YY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies CPT/HCPCS	Modifier	E Diagnosis Code	F $ Charges	G Days or Units	H EPSDT Family Plan	I EMG	J COB	K Reserved for Local Use
1	02 02 04	02 02 04	11	1	J9070	[redacted]	1	88 00	11				
2	02 02 04	02 02 04	11	1	J1100	[redacted]	1	50 00	10				
3	02 02 04	02 02 04	11	1	J9000	[redacted]	1	62 00	11				
4	02 02 04	02 02 04	11	1	J7 REDACTED	[redacted]	1	[illegible] 00	3				
5	02 03 04	02 03 04	11	1	90782	[redacted]	2	30 00	1				
6	02 03 04	02 03 04	11	1	J2505	[redacted]	2	3688 00	1				

25. FEDERAL TAX I.D. NUMBER: 04-3498186 — SSN [ ] EIN [X]
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] NO
28. TOTAL CHARGE: $ 4519 00
29. AMOUNT PAID: $ 3979 35
30. BALANCE DUE: $ 539 65

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
HETZEL, PAUL M.D.
LIC.# 039373 03/04/04
COMPUTER GENERATED

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
SPRINGFIELD MEDICAL ASSOC
2150 MAIN ST, STE 1000
SPRINGFIELD, MA 01104-000

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SPRINGFIELD MEDICAL ASSOC
P.O. BOX 219
WINDSOR, CT 06095-0000
PIN# — GRP#

MC (APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) 03/04/2004 0001842 — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Date: 3/08/2004
Time: 4:25PM

Page: 1

SPRINGFIELD MEDICAL ASSOC INC
PO BOX 219
WINDSOR, CT 06095
Phone: (800) 883-5985

MEDICARE REMITTANCE NOTICE

Provider/Clinic#: N51714

Check No/EFT Trace No: 127340082
Date Paid: 2/26/2004

NAME:

500

PERF PROV.	SERVICE DATES	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PAID AMT.
N51714	2/02/2004 2/02/2004	11	011	J9000		627.00	89.76	0.00	17.95	537.24	71.81
N51714	2/02/2004 2/02/2004	11	011	J9070		88.00	56.43	0.00	11.29	31.57	45.14
N51714	2/02/2004 2/02/2004	11	010	J1100		50.00	1.00	0.00	0.20	49.00	0.80
N51714	2/02/2004 2/02/2004	11	003	J7040		36.00	16.92	0.00	3.38	19.08	13.54
N51714	2/03/2004 2/03/2004	11	001	J2505		3688.00	2507.50	0.00	501.50	1180.50	2006.00
N51714	2/03/2004 2/03/2004	11	001	90782		30.00	26.66	0.00	5.33	3.34	21.33
PT Respon: 539.65						**Claim Totals:**	4519.00	2698.27	0.00	539.65	1820.73	2158.62

NATIONAL HERITAGE INSURANCE COMPANY
PROVIDER #: M20160
CHECK/EFT #:125103406 10/03/01

125103406 100001135
COMMONWEALTH HEMATOLOGY
PAGE #: 7 OF 11

MEDICARE REMITTANCE NOTICE

REDACTED

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME								ICN 0201264192940 ASG	Y MOA MA01		
J23017	0917 091701	11	1	99211		40.00	22.89	0.00	4.58 CO-42	17.11	18.31
J23017	0917 091701	11	1	96412		83.00	55.31	0.00	11.06 CO-42	27.69	44.25
J23017	0917 091701	11	1	96410		93.00	74.70	0.00	14.94 CO-42	18.30	59.76
J23017	0917 091701	11	5	J9045		785.00	555.55	0.00	111.11 CO-42	229.45	444.44
J23017	0917 091701	11	3	J9265		729.00	492.24	0.00	98.45 CO-42	236.76	393.79
PT RESP 240.14				CLAIM TOTALS		1730.00	1200.69	0.00	240.14	529.31	960.55
											960.55 NET

REDACTED

NAME								ICN 0201264192950 ASG	Y MOA MA01		
J23017	0917 091701	11	1	99211		30.00	27.27	0.00	5.45 CO-42	2.73	21.82
J23017	0917 091701	11	1	J7040		10.00	8.56	0.00	1.71 CO-42	2.44	6.85
J23017	0917 091701	11	10	J1260		230.00	164.50	0.00	32.90 CO-42	65.50	131.60
J23017	0917 091701	11	2	J1200		4.00	1.02	0.00	0.20 CO-42	2.98	0.82
J23017	0917 091701	11	5	J1100		30.00	1.25	0.00	0.25 CO-42	28.75	1.00
PT RESP 40.51				CLAIM TOTALS		305.00	202.60	0.00	40.51	102.40	162.09
											162.09 NET

NAME [redacted]											
A20005	0905 090501	11	1	99244		239.00	184.19	0.00	36.84 CO-42	54.81	147.35
PT RESP 36.84				CLAIM TOTALS		239.00	184.19	0.00	36.84	54.81	147.35
CLAIM INFORMATION FORWARDED TO: BC/BS OF MASS											147.35 NET

NAME [redacted]											
J02033	0903 090301	32	1	99312		76.00	57.89	0.00	11.58 CO-42	18.11	46.31
J02033	0904 090401	32	1	99312		76.00	57.89	0.00	11.58 CO-42	18.11	46.31
J02033	0906 090601	32	1	99311		46.00	36.09	0.00	7.22 CO-42	9.91	28.87
PT RESP 30.38				CLAIM TOTALS		198.00	151.87	0.00	30.38	46.13	121.49
											121.49 NET

NAME [redacted]											
J06591	0917 091701	11	2	J9190		10.00	6.08	0.00	1.22 CO-42	3.92	4.86
PT RESP 1.22				CLAIM TOTALS		10.00	6.08	0.00	1.22	3.92	4.86
											4.86 NET

NAME [redacted]											
J06591	0917 091701	11	1	99214		114.00	87.78	0.00	17.56 CO-42	26.22	70.22
J06591	0917 091701	11	18	J0640		396.00	299.16	0.00	59.83 CO-42	96.84	239.33
J06591	0917 091701	11	1	96408		60.00	46.63	0.00	9.33 CO-42	13.37	37.30
J06591	0917 091701	11	1	96410		93.00	74.70	0.00	14.94 CO-42	18.30	59.76
J06591	0917 091701	11	1	96412		83.00	55.31	0.00	11.06 CO-42	27.69	44.25
PT RESP 112.72				CLAIM TOTALS		746.00	563.58	0.00	112.72	182.42	450.86
											450.86 NET

NAME [redacted]											
J06591	0917 091701	11	1	J7050		10.00	9.09	0.00	1.82 CO-42	0.91	7.27
J06591	0917 091701	11	1	85024		17.00	11.70	0.00	0.00 CO-42	5.30	11.70
J06591	0917 091701	11	1	82378		35.00	26.22	0.00	0.00 CO-42	8.78	26.22
J06591	0917 091701	11	1	G0001		10.00	3.00	0.00	0.00 CO-42	7.00	3.00
PT RESP 1.82				CLAIM TOTALS		72.00	50.01	0.00	1.82	21.99	48.19
											48.19 NET

NAME [redacted]											
J23017	0917 091701	11	16	J9093		176.00	98.08	0.00	19.62 CO-42	77.92	78.46
PT RESP 19.62				CLAIM TOTALS		176.00	98.08	0.00	19.62	77.92	78.46
CLAIM INFORMATION FORWARDED TO: MAIL HANDLERS											78.46 NET

NAME [redacted]											
J23017	0914 091401	11	1	99215		168.00	129.28	0.00	25.86 CO-42	38.72	103.42
J23017	0917 091701	11	1	99212		52.00	40.38	0.00	8.08 CO-42	11.62	32.30
J23017	0917 091701	11	1	96408		60.00	46.63	0.00	9.33 CO-42	13.37	37.30
J23017	0917 091701	11	1	96410		93.00	74.70	0.00	14.94 CO-42	18.30	59.76
J23017	0917 091701	11	11	J9000		759.00	586.83	0.00	117.77 CO-42	170.17	471.06
PT RESP 175.98				CLAIM TOTALS		1132.00	879.82	0.00	175.98	252.18	703.84
CLAIM INFORMATION FORWARDED TO: MAIL HANDLERS											703.84 NET

NAME [redacted]											
J23017	0917 091701	11	1	J7040		11.00	8.56	0.00	1.71 CO-42	2.44	6.85
PT RESP 1.71				CLAIM TOTALS		11.00	8.56	0.00	1.71	2.44	6.85
CLAIM INFORMATION FORWARDED TO: MAIL HANDLERS											6.85 NET

DO NOT STAPLE IN THIS AREA

SHEET METAL WKRS HLTH FD
P O BOX 1449
GOODLETTSVILLE TN 37070

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)

REDACTED

3. PATIENT'S BIRTH DATE MM DD YY: 12 04 1935 SEX: M ☒ F ☐

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

HANOVER | STATE: MA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☒

ZIP CODE: 02339

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

REDACTED

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

c. OTHER ACCIDENT? YES ☐ NO ☒

10d. RESERVED FOR LOCAL USE

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

REDACTED

STATE

ZIP CODE 1751 | TELEPHONE (INCLUDE AREA CODE)

a. INSURED'S DATE OF BIRTH MM DD YY: 10 REDACTED SEX

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: SHEET METAL WKRS HLTH FD

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☒ NO ☐ If yes, return to and complete item 9 a-d.

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE B

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE 10/16/01
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: JAMES R EVERETT MD

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 162.9 NEOPLASM LUNG
2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 17 01		3	1	99211		1	40 00	1				
2 09 17 01		3	2	96410		1	93 00	1				
3 09 17 01		3	2	96412		1	83 00	1				
4 09 17 01		3	90	J9045		1	785 00	5				
5 09 17 01		3	90	J9265		1	729 00	3				
6 09 17 01		3	2	90780	59	1	68 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN: 04-3296910 ☒

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE $ 1798 00

29. AMOUNT PAID $ 1547 17

30. BALANCE DUE $ 250 83

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JAMES EVERETT, M.D.
SIGNED 10/16/01 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
REDACTED

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
COMMONWEALTH HEM-ONC
10 WILLARD STREET
QUINCY MA 02169
PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS

SECOND INSURANCE

[redacted]

MEDICARE PART B (866) 454-9007 MEDICARE REMITTANCE NOTICE
PROVIDER #: 00040967
CHECK/EFT #: 106730550 06/22/01 PAGE #: 21 OF 37

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NA[redacted]							ICN 52116221020-00 ASG Y			MOA MA01	MA18
10212Z	0509	050901	11	001	99214	130.00	80.69	0.00	16.14	CO-42 49.31	64.55
10212Z	0509	050901	11	001	85024	21.00	11.70	0.00	0.00	CO-42 9.30	11.70
										OA-93 0.00	
10212Z	0509	050901	11	002	J1440	514.00	342.76	0.00	68.55	CO-42 171.24	274.21
10212Z	0510	051001	11	001	99211	35.00	20.47	0.00	4.09	CO-42 14.53	16.38
10212Z	0510	051001	11	002	J1440	514.00	342.76	0.00	68.55	CO-42 171.24	274.21
10212Z	0510	051001	11	040	Q0136	800.00	473.60	0.00	94.72	CO-42 326.40	378.88
PT RESP 252.05					CLAIM TOTALS	2014.00	1271.98	0.00	252.05		742.02 1019.93
ADJS: PREV PD 0.00 PD TO BENE 0.00 INT						0.00 PRIMARY			0.00	OTHER OA93 0.00	
THE CLAIM IS BEING FORWARDED TO: AARP UNITED HEALTHCARE										1019.93 NET	
NA[redacted]										MOA MA01	
04373Z	0410	041001	11	001	99211 25	33.00	20.47	0.00	4.09	CO-42 12.53	16.38
04373Z	0410	041001	11	001	96410 59	110.00	65.90	0.00	13.18	CO-42 44.10	52.72
04373Z	0410	041001	11	001	J7050	20.00	10.59	0.00	2.12	CO-42 9.41	8.47
04373Z	0410	041001	11	004	J7051	8.00	3.80	0.00	0.76	CO-42 4.20	3.04
04373Z	0410	041001	11	050	J1642	80.00	13.00	0.00	2.60	CO-42 67.00	10.40
04373Z	0410	041001	11	003	J1100	30.00	1.71	0.00	0.34	CO-42 28.29	1.37
04373Z	0410	041001	11	006	J9265	1668.00	[redacted]	0.00	[redacted]	[redacted] 627.06	832.75
04373Z	0410	041001	11	032	J2405	320.00	[redacted]	[redacted]	38.9[redacted]	[redacted]42 125.44	155.65
04373Z	0410	041001	11	001	85024	21.00	[redacted]	[redacted]	[redacted]	[redacted] 9.30	11.70
										OA-93 0.00	
04373Z	0410	041001	11	001	90780 59	81.00	47.60	0.00	9.52	CO-42 33.40	38.08
PT RESP 279.71					CLAIM TOTALS	2571.00	1410.27	0.00	279.71		960.73 1130.56
ADJS: PREV PD 0.00 PD TO BENE 0.00 INT						0.00 PRIMARY			0.00	OTHER OA93 0.00	
										1130.56 NET	
NA[redacted]							ICN 52116221131-00 ASG Y			MOA MA01	MA18
46327Z	0406	040601	11	001	99211 25	33.00	20.47	0.00	4.09	CO-42 12.53	16.38
46327Z	0406	040601	11	001	96400	10.00	5.78	0.00	1.16	CO-42 4.22	4.62
46327Z	0406	040601	11	003	J9214	42.00	33.84	0.00	6.77	CO-42 8.16	27.07
46327Z	0406	040601	11	001	85024	21.00	11.70	0.00	0.00	CO-42 9.30	11.70
										OA-93 0.00	
46327Z	0409	040901	11	001	99211 25	33.00	20.47	0.00	4.09	CO-42 12.53	16.38
46327Z	0409	040901	11	001	96400	10.00	5.78	0.00	1.16	CO-42 4.22	4.62
46327Z	0409	040901	11	003	J9214	42.00	33.84	0.00	6.77	CO-42 8.16	27.07
PT RESP 24.04					CLAIM TOTALS	191.00	131.88	0.00	24.04		59.12 107.84
ADJS: PREV PD 0.00 PD TO BENE 0.00 INT						0.00 PRIMARY			0.00	OTHER OA93 0.00	
										107.84 NET	
NAME[redacted]							ICN 52116221025-00 ASG Y			MOA MA01	MA18
10212Z	0509	050901	11	001	99213	83.00	51.87	0.00	10.37	CO-42 31.13	41.50
PT RESP 10.37					CLAIM TOTALS	83.00	51.87	0.00	10.37		31.13 41.50
ADJS: PREV PD 0.00 PD TO BENE 0.00 INT						0.00 PRIMARY			0.00	OTHER OA93 0.00	
THE CLAIM IS BEING FORWARDED TO: AARP UNITED HEALTHCARE										41.50 NET	
[redacted]							ICN 52116221114-00 ASG Y			MOA MA01	MA18
23314Y	0507	050701	11	001	99214	130.00	80.69	0.00	16.14	CO-42 49.31	64.55
PT RESP 16.14					CLAIM TOTALS	130.00	80.69	0.00	16.14		49.31 64.55
ADJS: PREV PD 0.00 PD TO BENE 0.00 INT						0.00 PRIMARY			0.00	OTHER OA93 0.00	
										64.55 NET	
NA[redacted]							ICN 52116221013-00 ASG Y			MOA MA01	MA18
04373Z	0511	051101	11	001	99211	35.00	20.47	0.00	4.09	CO-42 14.53	16.38
04373Z	0511	051101	11	001	J1441	457.00	285.38	0.00	57.08	CO-42 171.62	228.30
04373Z	0511	051101	11	001	85024	21.00	11.70	0.00	0.00	CO-42 9.30	11.70
										OA-93 0.00	
PT RESP 61.17					CLAIM TOTALS	513.00	317.55	0.00	61.17		195.45 256.38
ADJS: PREV PD 0.00 PD TO BENE 0.00 INT						0.00 PRIMARY			0.00	OTHER OA93 0.00	
THE CLAIM IS BEING FORWARDED TO: HDM CORPORATION										256.38 NET	

18

Employee

REDACTED

12/01/2001
Date Issued

Amount Paid: $8.08

HANOVER, MA 02339

REDACTED

File Copy This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone (615) 859-0131 Toll-free (800) 831-4914

Claim No. 1620737

Check No. 0144786

Explanation of Benefits

SMW+ Program

08/28/2001	08/28/2001	$80.00	$0.00	$8.08	$8.08	$8.08

Comments:

dup corrected history 12.6.01 BK

REDACTED

REDACTED

Provider: JOHN C WAIN, MD
Participant SSN:
BJK Claim Number: 1620737

HANOVER, MA 02339

Processed by *Southern Benefit Administrators, Inc.*